SOUTH CAROLINA BUDGET AND CONTROL BOARD

EMPLOYEE INSURANCE PROGRAM

REQUEST TO AMEND PROTECTED HEALTH INFORMATION

INSTRUCTIONS:

Complete this form, or submit the information requested in any other written form to:

Director
Employee Insurance Program
1201 Main Street, Suite 300
P.O. Box 11661
Columbia, S.C. 29211

The Employee Insurance Program has 60 days from receipt to respond to your request and an additional 30 days may be needed to respond.

Name: _____ ID Number: __ __ __ / __ __ / __ __ __ __

Address: _____
(Street, P. O. Box)

_____
(City, State, Zip Code)

Telephone Number: _____ Date: _____

Please identify the protected health information that you would like to amend, and indicate how you would like to amend the information. Please include dates, health care provider, and related information.

_____
_____
_____

Please explain why you want to amend the protected health information cited above. Use additional sheets if necessary.

_____
_____
_____

Signature: _____